PART VI – DEDUCTIBLE EXPENSES

NOTE: Your income may be reduced by the amount of unreimbursed expenses of the veteran's or his/her child's last illness and burial and the veteran's just debts which were paid by you. Be sure to include as income in Items 27F and 28D any reimbursement received on these expenses or debts. See paragraph N of instructions for reporting payments and reimbursements made after filing of your claim.

29A. NAME AND ADDRESS OF PERSON TO WHOM PAID	29B. TOTAL AMT. OF EXPENSE OR DEBT	29C. NATURE OF EXPENSE OR DEBT	29D. DATE PAID	29E. AMOUNT PAID BY YOU
	$			$
	$			$
	$			$
	$			$
	$			$
	$			$

PART VII – MISCELLANEOUS INFORMATION

30. HAS A SURVIVING SPOUSE OR CHILD FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKER'S COMPENSATION PROGRAMS BECAUSE OF DEATH OF VETERAN ON WHOSE SERVICE THIS CLAIM IS FILED?

☐ YES ☐ NO

31. IS A CLAIM OR COURT ACTION PENDING, OR HAS A COURT DECREE AWARDING DAMAGES ON A SETTLEMENT OR COMPROMISE OF A CLAIM BASED ON THE DEATH OF THE VETERAN BEEN MADE?

☐ YES ☐ NO *(If "YES," explain in Item 37, "Remarks")*

32. IS A CLAIM FOR SURVIVOR BENEFIT PLAN (SBP) ANNUITY FROM A SERVICE DEPARTMENT PENDING OR AN AWARD OF THE SBP ANNUITY BEEN MADE BASED ON THE DEATH OF THE VETERAN?

☐ YES ☐ NO *(If "YES," explain in Item 37, "Remarks")*

33A. HAS THE SURVIVING SPOUSE OR CHILD FILED A CLAIM PREVIOUSLY WITH VA? ☐ YES ☐ NO *(If "YES," complete Items 33B through 35 inclusive)*	33B. NAME OF PERSON ON WHOSE SERVICE CLAIM WAS MADE	33C. RELATIONSHIP TO CLAIMANT
34. VA FILE NO.	35. OFFICE WHERE CLAIM WAS FILED *(City and State)*	
36A ARE YOU NOW A PATIENT IN A NURSING HOME? ☐ YES ☐ NO *(If "YES," complete Item 36B)*	36B. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COST? ☐ YES ☐ NO *(If "YES," give the name and address of nursing home in Item 37, "Remarks")*	

PART VIII – CERTIFICATION, AUTHORIZATION FOR RELEASE OF INFORMATION AND ADDITIONAL COMMENTS

37. REMARKS *(If additional space is needed, attach separate sheet)*

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION: I CERTIFY THAT the foregoing statements are true and complete to the best of my knowledge and belief. I CONSENT THAT any physician, surgeon, or hospital or other medical facility that treated or examined the veteran for any purpose, or that was consulted professionally, may furnish to the DEPARTMENT OF VETERANS AFFAIRS (VA) any and all information including but not limited to autopsy reports and laboratory reports concerning the veteran in connection with this claim for service-connected death benefits, and I WAIVE ANY PRIVILEGE WHICH RENDERS SUCH INFORMATION CONFIDENTIAL.

38. SIGNATURE OF CLAIMANT, CUSTODIAN OR GUARDIAN	39. DATE SIGNED

WITNESSES TO SIGNATURE OF CLAIMANT IF MADE BY "X" MARK

NOTE: A signature by mark must be witnessed by two persons to whom the person making the statement is personally known. The witnesses must sign their names in Items 40A and 40B and type or print their names and addresses in Items 41A and 41B.

40A. SIGNATURE OF WITNESS	39B. SIGNATURE OF WITNESS
41A. NAME AND ADDRESS OF WITNESS *(Type or print)*	41B. NAME AND ADDRESS OF WITNESS *(Type or print)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.